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ABSTRACT

This document presents a review of the literature on salient ethical issues in marriage and family counseling. Issues addressed in the paper include: (1) defining the client and the welfare and rights of individuals versus those of the family system; (2) issues of informed consent and manipulative therapeutic interventions; (3) issues related to family members who decline to participate in treatment; (4) confidentiality, including dealing with family secrets and child abuse; (5) the use of the Diagnostic and Statistical Manual of Mental Disorders (Third Edition-Revised); and (6) differing counselor and family values. Two ethical decision-making models are presented along with their applicability to marriage and family counseling. Finally, the implications for marriage and family counselor training are discussed. It is noted that counseling programs have traditionally focused on individual and group counseling theories, techniques, and practice, and that as more training programs offer marriage and family coursework and specialization, more emphasis may need to be given to ethical issues unique to this area. (NB)

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Marriage and Family Therapy

and

Traditional Counselor Education Programs

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Running head: ETHICAL DILEMMAS IN MARRIAGE AND FAMILY COUNSELING

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Abstract

A review of the literature on salient ethical issues in marriage and family counseling including defining the client, informed consent, non-participating family members, confidentiality, diagnostic systems, power- and control issues, and differing counselor and family values is presented. Two ethical decision-making models and implications for marriage and family counselor training are included.

Marriage and Family Ethical Dilemmas

and Traditional Counselor Education Programs

Increasing numbers of mental health professionals are practicing marriage and family counseling (Huber & Baruth, 1987; Margolin, 1982). If training for those engaging in marriage and family counseling has been primarily offered in programs focusing on individual and group counseling, various legal and ethical issues arising in marriage and family counseling may not have been included in these programs (Huber & Baruth, 1987). As a result, traditionally trained counselors may find it necessary to make difficult ethical decisions for which they are poorly prepared.

The fields of counseling and psychology have striven to be sensitive to ethical issues in clinical practice. This is evidenced by the establishment of various professional codes of ethics, the updating of these codes that reflect cultural changes, the requirement of a course in professional ethics by numerous state licensing and certifying boards, and by the variety of publications on ethical issues.

Van Hoose and Kottler (1985) identified the universality of ethical codes among the professions. These codes serve a number of purposes. In particular, they reflect the concerns of the profession and provide basic ethical principles to facilitate members when conflict occurs. Historically an essential element in training has been an awareness of ethical practices for those providing counseling services (Wilcoxon & Gladding, 1985). Mental health professionals

have an obligation to evaluate the meaning of ethically benefitting others and to avoid harming them by the very nature of their role (Kitchner, 1986).

Experienced clinicans make appropriate ethical decisions which they may rarely note. Woody (1990) suggests that this reflects an internalization of the basic ethical principles. Therefore, appropriate judgements are often automatic. Ethical dilemmas emerge when conflict exists between two or more principles (Hare, 1981) and when different courses of action are possible, for contradictory ethical reasons (Kitchner, 1986). Hundert (1987) notes that a difficult ethical problem becomes a dilemma when it is believed that an ethical error is possible regardless of the decision.

Huber and Baruth (1987) posit that individual and marriage and family counseling contrast on both conceptual and pragmatic levels. These differences center on the perspective regarding psychological dysfunction. In adopting a systemic (marriage and family) perspective, causes are viewed as circular not linear (individual) (Aponte, 1985; Nichols, 1984). Individual symptoms are thus seen as being viewed from the interpersonal context (Huber & Baruth, 1987) which serves a regulating, stabilizing, and communicating function in that context (O'Shea & Jessee, 1982). This perspective focuses on the interaction between individuals rather than on the characteristics of a given person (Sluzki, 1978). When a person's actions and/or characteristics are the focus of a therapeutic session they are explored in terms of how these shape the actions and reactions of other members of the system (Huber & Baruth, 1987).

Margolin (1982) suggests that considering the couple or the family as the active, whole unit represents a conceptual change for individually trained counselors.

In addition, ethical guidelines for individual and group counseling may not always be sufficient or even directly applicable to family therapy (Margolin, 1982). Miller, Scott, and Searight (1990) suggest that most ethical codes follow linear causality and when counselors encounter issues in family counseling which are non linear in nature and involve the rights of more than one person they may be unprepared to meet the ethical challenge. Even normally simplistic issues such as who the client is and the notion of client welfare can be confusing in family counseling (Okun & Rappaport, 1980). In addition, ethical codes developed specifically for marriage and family counselors i. e., the American Association of Marriage and Family Therapy's (AAMFT) Code of Ethics (1988), are themselves often insufficient in dealing with the complex ethical issues encountered in family counseling (Green & Hansen, 1989).

The focus of this article is centered on reviewing the literature on the complex ethical issues which may arise in family counseling including defining the client and the welfare and rights of individuals versus those of the family system; issues of informed consent and manipulative therapeutic interventions; issues related to family members who decline to participate in treatment; confidentiality, including dealing with family secrets and child abuse; the use of the DSM-III-R; and differing counselor and family values. Two ethical

decision-making models will be presented along with their applicability to marriage and family counseling. Finally, the implication for training in counselor education programs will be explored. However, as Hines and Hare-Mustin (1978) state, the ethical issues involved in marriage and family counseling are extremely complex and total agreement or resolution may never be fully realized.

Literature Review

Defining the Client

Margolin (1982) suggests that protection of client welfare is a fundamental responsibility of the counselor. Boszormenyl-Nagy (1985) also acknowledges that one of the primary obligations of the counselor is to the client. A frequent ethical dilemma encountered in family therapy stems from the ambiguity regarding the identification of the client. In individual counseling the counselor is responsible for one person, identified as the client. In marriage and family counseling this issue becomes more complex (Fenell & Weinhold, 1989). Deciding whose best interest is to be served can become confusing (Hines & Hare-Mustin, 1978; Margolin, 1982; Morrison, Layton, & Newman, 1982; Sider & Clements, 1982), especially when each family member, the relationship between members, and the system itself needs to be considered (Corey, Corey, & Callahan, 1984).

Part of the dilemma results from the fact that what promotes the welfare of one family member may not promote the welfare of another (Fenell &

counselor may be imposing a new set of values and beliefs on the family (Huber & Baruth, 1987). These ideas involve the acceptance of circular causality and the fact that the identified patient serves a strong stabilizing function within the family (O'Shea & Jessee, 1982). Huber and Baruth note that this may be especially problematic in North American culture which is considered highly individualistic and in which personal rights have priority.

Although viewing the system or the relationship as the client is usually productive (Margolin, 1982) there is widespread disagreement regarding when the needs of the individual family members take precedence over the family's needs. In order for a fundamental change to occur in the family system, individuals may, as a by-product, experience distress. Hoffman (1981) suggests that this distress needs to be raised to a "crisis" level for change to occur. O'Shea and Jessee (1982) are concerned about how much distress any one member of the family should be required to tolerate in order that the relationship system experience long-term benefits.

Margolin (1982) insists that maintaining the interests of the family system over the individual is ill-advised in certain circumstances. A suicidal individual treated by a systems perspective may leave the counselor in a precarious position (Huber & Baruth, 1987). Yet in safeguarding the suicidal family member, the counselor may be reinforcing that individual's continued scapegoating and the dysfunction of the family system (Langsley & Kaplan, 1968).

Weinhold, 1989; Hines & Hare-Mustin, 1978; Jenson, Josephson, & Frey, 1989; Zygmond & Boorhem, 1989). Thus, the immediate ethical dilemma centers on identifying whose welfare the counselor is ethically bound to protect (Patten, Barnett, & Houlihan, 1991). Jenson et al. (1989) believe it is imperative that in family counseling situations, counselors must be certain about who the client is and in whose best interest they are prepared to act.

This is not an easily resolvable issue. AAMFT (1988) states that marriage and family therapists are committed not only to the advancement of the welfare of families but also of individuals. The family includes at least two major systems: the entire family and the individual members that make-up that family (Boszormenyl-Nagy, 1986). Systems theory, according to Sider and Clements (1982), suggests that every family problem is a problem for the individual family member.

There is general consensus in marriage and family counseling that the primary client is the family system (Huber & Baruth, 1987; Watkins, 1989). Margolin (1982) indicates that this stance aids the counselor in working constructively with clients given the conflicting needs. She also notes that this position is usually effective but does not entirely eliminate a multitude of dilemmas.

When the problem is identified as a relationship or systems problem an assumption is made that immediately raises an ethical concern (Fieldsteel, 1982). By redefining presenting problems as relationship problems, the

In issues of family violence, the same dilemma is encountered. The abused member is seen from the systems perspective as actively fulfilling a stabilizing function within the family system (Huber & Baruth, 1987). By removing the abuser and safeguarding the abused the dysfunctional dynamics may be maintained in the family.

There are other issues that may have less salience but are critical nonetheless. One involves the possibility that individual family members may suffer high levels of anxiety, embarrassment, and a loss of respect due to self-disclosure in family therapy (Hines & Hare-Mustin, 1978). Another issue involves determining when termination occurs in family therapy. Wilcoxon and Gladding (1985) note that the answer hinges on whether the goal is satisfaction for all family members or a more functional family system in general.

Some system "purists" would advocate that the client is the family and its needs always take precedence over those of individual family members (Watkins, 1989). Others suggest that individuals may have to subordinate their own needs while the family needs are being met (Patten et al., 1991). Individual needs are possibly equal but usually secondary. However, when the welfare of an individual is in jeopardy, Huber and Baruth (1987) and Margolin (1982) strongly recommend that individual needs takes priority.

Ethical dilemmas regarding client welfare certainly occur in individual counseling. However, in marriage and family counseling they are much more complex. Dilemmas arise due to the nature of counseling multiple individuals

which are not often covered in professional codes of ethics. Nonetheless, they are frequently encountered. It is perhaps important to remember that the therapeutic contract in family counseling implies not only a responsibility to the system but to each family member as well (Hines & Hare-Mustin, 1978).

All other things being equal, not harming others is generally a stronger ethical mandate than benefitting others (Kitchner, 1986). Kitchner in her discussion on ethical decision-making suggests that when the ethical decision is between potential risk and potential harm, the stronger obligation would be to avoid harm. Zygmond and Boorhem (1989) suggest that choosing interventions which benefit the family and, at the same time, minimize any harmful outcomes is an ethical and therapeutic decision.

Informed Consent

A growing concern of mental health professionals regarding informed consent is reflected in the literature. In marriage and family counseling this concern has been sparked by the problem of identifying the client (Jenson et al., 1989). Margolin (1982) sees this trend as a recognition of clients as consumers and the increasing legal regulation of the mental health field. Additionally, the profession's commitment to informed consent stems from concerns regarding the respect of client autonomy (Kitchner, 1986). Informed consent has been defined as gaining the client's consent to being involved in the counseling process (Stricker, 1982) and being informed of the procedures to be used and the possible risks and benefits of such approaches (Corey et al.,

1984).

Because so much discussion surrounds defining the identity of the client for marriage and family counselors, informed consent of all members of the family becomes an important issue (Fennel & Weinhold, 1989). Obtaining informed consent of all family members who may enter the therapeutic process at a later time is also recommended (Margolin, 1982). If children participate in family counseling it is recommended that they, too, be included in the informed consent process (Basel, 1989). This is particularly salient when the child is opposed to counseling (Morrison et al., 1979). Kitchner (1986) recognizes that infants may be incompetent to participate in this process and that younger children may have limited abilities to give informed consent. Yet, including children in the process even if they are not competent to give formal consent is preferable than to leaving them out (Margolin, 1982).

Huber and Baruth (1987) note that frequently simple descriptions of procedures, possible experiences, and effects are sufficient to reduce most anxiety experienced by clients. More detail is particularly necessary when there are risks involved and possible negative as well as positive benefits (Jenson et al., 1989). Due to the differences in risks and benefits between marriage and family counseling and individual counseling, discussing the negative effects in family counseling is especially important (Huber & Baruth, 1987). Huber and Baruth also suggest that clients need to be prewarned of the possibility of negative outcomes for different family members in order to reduce

the associated risks. Hare-Mustin (1980) recommends that counselors be very explicit about the primacy of the relationship goals and the extent to which individual goals may be incompatible with the system goals.

Communicating to clients a theoretical commitment to a systems perspective becomes an important component in informed choice procedures in marriage and family counseling (Huber & Baruth, 1987; Margolin, 1982). Therefore, if the position is incompatible with the values of the family or individual family members the degree of incompatibility and goals can be discussed (Hare-Mustin, 1980) and clients can make an informed decision as to whether they want to become involved in the counseling process (Leigh, Loewen, & Lester, 1986).

It has been recommended that the following types of information be provided to marriage and family clients in order to help them make informed choices: a) the procedures and goals of the counselor, b) any reasonable harmful effects or risks, c) reasonable potential benefits, d) qualifications, policies, practices, and theoretical orientation of the counselor, e) assurance that the family members can withdraw his or her informed consent and discontinue counseling at any point and, f) alternative referral sources for treatment (Hare-Mustin, 1980; Huber & Baruth, 1987; Margolin, 1982). Therefore, if risks are involved, informed consent guarantees that individuals will only be exposed to them voluntarily (Leigh et al., 1986).

Margolin (1982) is not convinced that even with an accurate portrayal of

counseling procedures and practices that the counselor will be able to be truly objective. Huber & Baruth (1987) note the need for counselors to carefully examine how their therapeutic orientations influence their informed consent practices. Some counselors believe that providing a great deal of information is detrimental to the therapeutic process (Haley, 1976). The degree of information specificity may be determined by theoretical orientation.

Nevertheless, informed consent can provide families with a cognitive readiness for some of the discomfort and anxiety they may experience (Jenson et al., 1989). Informed consent involves more than just enabling families to make informed decisions. It also gives clients the opportunity to become involved in the decision-making process and facilitates the establishment of the therapeutic alliance.

The Treatment Unit

Controversial ethical issues arise around who should be included in the therapeutic process in marriage and family counseling. A much debated ethical issue revolves around the refusal to treat a family without all family members being present (Huber & Baruth, 1987; Patten et al., 1989). In a study conducted by Green and Hansen (1986) it was found that the two top ethical dilemmas encountered by marriage and family counselors were treating a family member if one member does not want to participate and seeing family members without the others present. This practice of withholding services until all family members are engaged in treatment stems from the battle for structure

observed by Napier and Whitaker (1978). They suggest that this battle for structure, which involves administrative control and includes scheduling, fees, and who participates in the sessions, needs to be won by the counselor. Napier and Whitaker further suggest that the engagement of all members is seen to be therapeutically significant.

Withholding sessions and denying services until all members agree to participate is seen as distinct; the first is viewed as an unethical practice and the second a therapeutic strategy (Wilcoxon, 1986). Although O'Shea and Jessee (1982) acknowledge that the practice of withholding services is highly controversial, they argue that it is clearly a responsible and competent procedure. Gurman and Kniskern (1981) suggest that when a systemic format is not used in family counseling it may well produce negative therapeutic outcomes rather than problem resolution. However, they also note that the effectiveness of particular treatments for particular clients has not been sufficiently tested empirically.

Ethical problems with this practice may involve the issue of voluntary participation (Margolin, 1982). Teismannn (1980) questions whether this constitutes an ethical problem based on refusing to serve motivated family members. For counselors employed in public agencies funded by tax dollars such withholding of services would not only create ethical problems but legal and political ones as well (Huber & Baruth, 1987).

Several alternatives have been proposed in attempts to address this

dilemma. Huber and Baruth (1987) suggest that the reluctant family member be encouraged to participate in the initial assessment. Wilcoxon and Fenell (1983) recommend that a letter containing the research findings in marital counseling, particularly on one-spouse intervention be sent home with the attending spouse, along with an invitation to participate in treatment. Teismann (1980) makes several alternative suggestions that include: a) brief sessions with the attending members that only focus on a plan for engaging the non-participant, b) an agreement between the non-attenders and the counselor for a single, private session in return for a conjoint session, c) audio or videotaping segments of sessions for non-attenders and, d) an agreement for short-term counseling for the attending members.

For counselors who are unwilling to see the family without full family participation in counseling, it is suggested that a referral be made to another counselor rather than to deny services to motivated family members (Margolin, 1982). She recommends that the family be informed that not all counselors insist on seeing the entire family.

Confidentiality

Numerous ethical dilemmas can quickly arise in the area of confidentiality while counseling with couples or families. Most professional organizations provide ethical standards and guidelines for their members and AAMFT is no exception. In the AAMFT Code of Ethical Principles for Marriage and Family Therapists (1988) the overriding principle concerning confidentiality is

that respect for the confidences of their clients be shown by practitioners. Thus, it is the responsibility of counselors to state openly and clearly their positions on the issue of confidentiality. Respectful consideration of clients' confidentiality when dealing with multiple clients is not always a simple task. Family secrets pose unique confidentiality dilemmas for family counselors.

Secrets involve information that is differentially shared between family members. The types of secrets encountered in family counseling include: individual secrets which are withheld from other family members, internal family secrets in which several family members withhold information from other members of the family, and shared family secrets or those which are known by all family members but withheld from outsiders (Karpel, 1980).

Disagreements exist among professionals on the proper approach in dealing with family secrets. Some counselors may simply indicate that secrets will not be kept from spouses or other family members (Hines & Hare-Mustin, 1978; Weiner & Boss, 1985) or in the case of absolute confidentiality that information shared with the counselor will not be shared with anyone else (Watkins, 1989). However, several professionals suggest that a more productive middle ground would be to state at the beginning of therapy that "any information provided may be used by the therapist in the interest of helping to resolve presenting issues" (Fenell & Weinhold, 1989, p. 290). Issues to be considered in revealing family secrets would include: sensitivity to the timing, consequences for the unaware family member, and strategies which would

attempt to minimize the risk and potential negative effects that most likely contribute to mutual trust (Karpel, 1980).

Margolin (1982) supports an intermediary position and states that if information is gained from a spouse or family member in an individual session, the counselor should indicate that in general, confidentiality conditions are not applicable. However, the client has the right to request that certain pieces of information remain confidential and the counselor should comply. Another preventive approach to secrets involves discussing the dangers secrets pose in family counseling and exploring techniques for managing family secrets (Karpel, 1980). Wendorf & Wendorf (1985) believe that the content of the family secrets are irrelevant and the focus should be placed on dealing with the dysfunctional dynamics that family secrets reveal. They contend that the secret would represent a pattern that would be found in many other interactions within the family. The secret would just be one example of the problematic family dynamics.

The position counselors take on secrets has a therapeutic impact. Karpel (1980) notes that there are strong loyalty dynamics in the creation and maintenance of secrets. He suggests that an element of power may also be involved which could lead to destructive disclosures of secrets. Additionally, internal family secrets serve family functions which can strengthen boundaries and alliances between secret-holders. At the same time, unaware family members may experience estrangement and later feel deceived after the secret

has been revealed. When secrets are held within the family they may serve to strengthen the boundary from the outside world.

Several ethical issues arise when contending with family secrets. Karpel (1980) suggests that the counselor's trustworthiness can be jeopardized and the secret-holder may use the secret in unanticipated and destructive ways. If counselors become triangulated and are prevented from discussing the secret, they may end up being impotent in affecting therapeutic change. Countertransference issues towards the triangulator such as guilt, resentment, and anxiety may also emerge (Karpel, 1980).

Recently, Green and Hansen (1989) conducted research on the actual practice of family therapists relative to eight dilemmatic issues. One such vingette dealt with a therapist who had been working with a family for three months. The wife called the therapist and reported that she had been having an affair, that she planned to leave the family and remarry but did not want this information shared. Of the 202 participants in this study, 63.1% indicated that they would accept the woman's confidence, but only under the condition that she share her secret in a "reasonable" amount of time. However, 36.9% of the respondents disagreed with this decision. In addition, 26% indicated that they would announce at the beginning of therapy that they would not tolerate secrets and risk losing the family by sharing this information and 14.2% stated that they would share this information with the family because to not do so would influence the family process in a negative way. The results of this research suggest that a

lack of strong agreement on the proper approach for dealing with issues of confidentiality within a marriage and family context remains dominant in the counseling profession.

When the behavior of family members has legal ramifications especially in the case of abuse, there is greater agreement regarding proper behavior on the part of the counselor. Margolin (1982) points to the fact, however, that legal prescriptions are much clearer as they relate to child abuse reporting than they are to spouse abuse. In the Green and Hansen (1989) study, child abuse was reported as the most significant ethical dilemma faced by family therapists. In a situation regarding reporting child abuse, although nearly 70% of the respondents indicated that they would report child abuse to the authorities, nearly half indicated they would delay reporting child abuse until it happened again.

The boundaries of confidentiality in individual counseling create consternation among practitioners. These boundaries are even more complicated in family counseling. It is apparent from the above discussion that agreement is lacking as to the extent of these boundaries among family counselors.

The Use of DSM-III-R

Incompatibility With Systems Perspective. While little attention has been paid to the ethical dilemmas created by the use of traditional diagnostic systems by the family counselor, arguments about the risks involved in diagnostic labeling are not new (Szaz, 1961). Concerns have been raised about the potential of harm

caused by labeling in all types of counseling (Kitchner, 1986). Traditional diagnostic systems, such as the DSM-III-R (American Psychiatric Association, 1987), have generally not been useful to family counselors because they assume that the causes of psychological and behavioral problems lie primarily within an individual. These approaches ignore and at times conflict with the basic assumptions of family systems (Huber & Baruth, 1987) which focus on the relationships among people (Frances, Clarkin, & Perry, 1984). Haley (1987) suggests that traditional approaches are basically incompatible for many family counselors.

This incompatibility may cause ethical dilemmas for some family counselors. These concerns center around such issues as who in the family receives a diagnostic label, how this decision is made, and the consequences to the family, the labeled individual, the treatment process, and treatment outcomes. Huber and Baruth (1987) suggest that such diagnoses support underlying pathological conditions within the family or the environment. Denton (1989) states that an initial goal in family counseling is to change the focus from centering on an individual family member to that of family interactions which can be supporting the individual's problem behavior. If family counselors use a systems approach with a family and then identify one person in the family as having the problem, this may appear to the family as support for their original perspective that one family member is causing the family problems (Huber & Baruth, 1987).

The potential for causing harm to either an individual family member or the family system by use of traditional diagnosis is ever present. Family counselors who use the DSM-III-R diagnostic system despite criticism, hopefully base their decision on the belief that the benefits outweigh the harm (Kitchner, 1986).

Misrepresentation. Smith (1981) criticizes mental health professionals who use a diagnostic system primarily to obtain third party reimbursements. In an era when many clients use third party payments for mental health services many family counselors may conceptualize and treat families using one model, i.e., a systems model, and still another approach, the traditional diagnostic model primarily to obtain payments. Part of the dilemma is that insurance companies and other third party reimbursers only provide payment for an individual mental disorder. This stems from the traditional psychiatric view which is often termed "descriptive", "biological", or "medical" (Denton, 1989). As Denton notes, V codes in the DSM-III-R can be used for family problems but are often seen by insurance companies as problems in living and therefore are not reimbursable.

However, family counselors who provide a pathological diagnosis which they do not believe in, raise the ethical and legal issue of misrepresentation which according to Denton (1989), constitutes fraud. Such family counselors could be said to be sacrificing their integrity for material gain (Smith, 1981). However, traditional diagnoses may cause little problems for family counselors

whose conceptualizations of family counseling incorporate a contextual perspective which include the biological, individual, family, and social systems (Engel, 1980).

Use of traditional diagnostic systems can cause concerns for many counselors. Unique issues arise in family counseling due to the differences in orientations between family counseling and traditional conceptualizations of individual psychopathology (Shackle, 1985). In most cases, openly discussing this concern with the family and involving them in the decision-making process is a possible ethical solution (Denton, 1989). Nonetheless, the family counselor must grapple with the ethical issues involved in the use of traditional diagnostic systems which include the possible negative effects on individuals and the pressures to misrepresent diagnoses.

The Use of Power and Control

Most counselors would agree that there is some measure of control in all forms of therapy and, as Haley (1987) states, the process of counseling itself involves the manipulation of people in order to influence them to change. Power and control strategies are particularly vital components of family counseling. Theoretical conceptualizations about the family, in fact, are based on the use of these strategies (Heatherington, 1990). Minuchin (1974) states that change in the family system is achieved primarily by the counselor's use of power. Miller et al. (1990) note that, pragmatically, family counselors are in a position of power relative to the family. While there is consensus regarding the necessity of

using power and control among family counselors, concern has been raised regarding the manipulative use of these strategies and their potential for misuse (Huber & Baruth, 1987). Several of the strategies used are controversial due to potential ethical dilemmas posed by their use. These include strategies which involve unilateral decision making by the counselor, deceiving the family by use of covert strategies, and the withholding of information from the family.

Unilateral Decision-Making. Many of the decisions that family counselors make involve the structure and boundaries of the therapeutic process (Heatherington, 1990). Heatherington notes that these decisions include problem identification, goal setting, rules regarding the sessions themselves, and the amount of information to be shared with the family regarding treatment. There is disagreement in the field of family counseling regarding the degree to which these decisions should be made unilaterally by the family counselor.

Whitaker and Bumberry (1988) assert that taking control in the decision making process reassures family members that the counselors are in control although they themselves may be feeling out of control. This they believe enables clients to trust the counselors in the therapeutic process. Heatherington (1990) notes that the use of control is important in therapy. She believes that facilitating family members in altering their problematic interpersonal relationships requires that the counselor control client behaviors such as interruptions, instructions, and praise. These counseling techniques are aimed at preventing rambling, repetitive arguing, disengaged silence, enmeshed

speaking for others, and other problematic sequences (Metcoff & Whitaker, 1982).

However, Huber and Baruth (1987) suggest that client dependency may be encouraged as family counselors establish their sphere of influence thereby reducing the autonomous functioning of the family. Miller et al. (1990) add that it may also interfere with the family's development of its own coping mechanisms. There is some concern that controlling the decision making process may be detrimental to women in particular. Weiner and Boss (1985) caution the use of control strategies that may reinforce dependency in women due to their prior socialization for dependency and submission. The American Psychological Association (APA) (1975) states that when power is exerted in therapy that it should not maintain or reinforce stereotypical dependency in women.

The ethical dilemmas which arise in the use of unilateral decision-making involve both the welfare and autonomy of individuals and the family system. As Heatherington (1990) notes in her analysis of the various family theories there is a great deal of variability in family counseling regarding the unilateral use of decision-making by family counselors.

Manipulative Strategies. The use of covert strategies in family counseling is highly controversial. These strategies include reframing, one-downmanship, paradox, confusion, concealing versus facing insight, hypnotic language, and the need to take and change sides (Haley, 1987; Heatherington, 1990). The use of paradoxical procedures is particularly controversial (Patten et al., 1991).

A paradox is usually an encouragement of symptom exaggeration in an individual or family. These interventions are intended to alter problematic interpersonal sequences by indirect methods (Huber & Baruth, 1987). Haley (1987) suggests that theses strategies encourage family change by arranging a situation to facilitate the initiation for change by the family. He assumes that the family will not accomplish change through more direct interventions. Therefore, he encourages the client to rebel against the counselor by not complying with the directive -- exaggerating the symptom. The covert strategy is used to evoke change. This often requires selective disclosure by the counselor to the family (Huber & Baruth, 1987).

Another major issue involves whether harm may be caused to clients by the use of such deceit (Green & Hansen, 1989; O'Shea & Jessee, 1982; Wendorf & Wendorf, 1985). Patten et al. (1991) suggest the use of deceit involved in covert strategies may cause families to terminate prematurely, may encourage family members to engage in problematic sequences more frequently, and may cause families to feel they are not being taken seriously. These may result from misinterpretation of the counselor's intent. Informed consent dilemmas may also arise from the use of deceit (Margolin, 1982; Miller et al., 1990).

Haley (1987) acknowledges that family counselors need to be cognizant of the long-term effects of deceit on clients. He suggests that these be weighed against the potential client benefits. Heatherington (1990) expresses concern that the therapeutic goals may be shaped by the counselor's own culture and

values without necessarily being recognized by the counselor. She also expresses concern that the use of such techniques may evoke negative reactions towards the counselor and the counseling profession.

A strong ethical case has been made by Haley (1987) that paradoxical interventions have a beneficial effect on families. Some family counselors believe the use of covert techniques are more of a treatment issue than an ethical one and Haley indicates that these strategies provide a systemic, circular perspective of treating families. In addition, he notes that change in family counseling is not achieved through self-understanding and insight.

The argument is made that the use of paradoxical procedures are in fact not deceitful because their use recreates the situation experienced by the family (Fisher, Anderson, & Jones, 1981; O'Shea & Jessee, 1982) by bringing the covert family patterns to the surface (Watzlawick, Weakland, & Fisch, 1974). Papp (1980) believes the paradoxical statement addresses the truth from a systems perspective. Minuchin (1978) states that these techniques are intrically bound to the therapeutic change process although they may appear to be unethical. However, Miller et al. (1990) argue that there is no empirical evidence which suggests that long-term changes are obtained using covert strategies in family counseling. In fact, they suggest that the use of these techniques are basically based on adherence to particular ideological beliefs.

Some family counselors are uncomfortable with the use of covert strategies under certain circumstances. For example, Stuart (1980) believes

that if the use of these techniques undermines trust in the therapeutic relationship or if the family is harmed through feeling misunderstood and neglected then the use of these techniques is clearly unethical. Nichols (1984) questions their use without explicit explanations being presented to the family. Other family counselors believe that to be dishonest with clients is to be unethical (Wendorf & Wendorf, 1985). They see the use of paradoxes as not only problematic but unnecessary. Treacher (1988) indicates that the use of deception reflects a basic unhumanistic perspective of families.

Some attempts have been made to reconcile the differences reflected in the use of covert strategies in family counseling. It has been recommended that decisions regarding the use of these strategies be made on a number of different factors. Miller et al. (1990) and Nichols (1984) suggest that covert strategies be used when direct ones have been unsuccessful. Heatherington (1990) suggests that characteristics of the client should be considered before using indirect counseling methods. Shoham-Salomer, Avner, and Neeman (1989) state that these procedures work best with families that are highly resistant.

Clearly there is strong disagreement regarding the use of covert strategies in family counseling. Green and Hansen's (1989) study indicates that the ethical dilemma involving manipulation of the family for therapeutic benefit is one of the most frequently encountered ethical dilemmas for family counselors. These results suggest that their participants are willing to use paradoxes in some situations but not in others. Unfortunately, the rationale for their differential

decisions was not investigated. The major issues in the use of covert strategies in family counseling, however, appear to revolve around the welfare of the client(s) and the ethics involved in the use of deceit.

Differing Counselor and Family Values

Values versus Ethics. Awareness of one's own values is exceedingly important for the marriage and family counselor because of the impact that culture, ethnicity, race, gender, and socioeconomic status have on the conduct of therapy (Aponte, 1985). Taking this even a step further, Haley (1987) and Miller et al. (1990) point to the need for counselors to be even more succinctly aware of the ramifications of their own ideology and therapeutic approach in interpreting the goals of counseling.

This interest in values and ethics can be attributed to several recent circumstances. The women's movement has had a significant impact on the implications of sex roles and women's equality in therapy (Hare-Mustin, 1980; Hines & Hare-Mustin, 1978). The emergence of state laws regulating mental health practices has made professionals more aware of values and ethical issues (Doherty, 1985).

However, values and ethics are different entities. Rokeach (1973) provides definitions which demonstrate these differences.

> Values are not always ethical. Values are enduring beliefs that specific models of conduct are personally or socially preferable to opposite modes of conduct. Ethics, however, is a system of ethical

> values and ethical theories, which are used to determine what is right in general, not what promotes the welfare of a specific individual or group while harming other individuals or groups. When ethical values are acted upon, they can protect the interests and welfare of all people involved (p. 270).

Counselors need to become aware of their personal and group values and understand how these differ from ethical values. Personal values may not always result in ethical decisions and as a result their clients' interests and welfare may not be protected (Zygmond & Boorhem, 1989)

Clearly, family counselors need to be upfront on their positions on such family issues as marriage, sex, parenting, and divorce (Okun & Rappaport, 1980). However, as Hines and Hare-Mustin (1978) suggest, counselors are often unaware of the extent to which their own personal and professional values impact the therapeutic process. Sider and Clements (1982) note that even the choice of counselors' therapeutic orientations may be a reflection of their values. Margolin (1982) has reviewed three value conflict areas which can significantly impact the process of therapy: preservation of the family or marriage, extramarital affairs, and sex roles.

Preserving the Marriage and Family. Counselors should be very clear about their own values regarding divorce and not attempt to persuade clients to accept either alternative. The role of the counselor is to "help the couple identify issues in the marriage to be resolved and to help the partners make a joint decision

about whether to stay in the marriage or to divorce" (Fennell & Weinhold, 1989, p. 293). Few marriage and family counselors would deny forming an opinion about the success of a relationship in question. However, a lack of agreement on whether these opinions should be expressed is clear. In a debate on this issue by Yoell, Stewart, Wolpe, Goldstein, and Speirer (1971), Wolpe indicated that frequently counselors need to make decisions for their clients and if the prognosis for happiness in a relationship is minimal then the counselor should advise divorce and assist in bringing it about. However, in the same debate, Stewart indicated discomfort with making decisions for a client. Gurman (1985) would agree and states that saving or dissolving a marriage is the responsibility of the clients. Developing an awareness of one's own predilection toward either the dissolution or perpetuation of marriages is the best defense a counselor can have in minimizing the effects of these biases on couples (Margolin, 1982).

Extramarital Affairs. Fenell and Weinhold (1989) state that the counselor's attitude toward extramarital affairs can be a hindrance to therapy if it conflicts with the position of one or both of spouses involved in therapy. Counselors who favor extramarital affairs may be in direct conflict with a spouse who does not. If counselors are opposed to such relationships, they must be cautious not to side with the faithful spouse if such a circumstance exists in therapy. Several potential drawbacks to advocating extra-marital affairs for clients have been identified: even if the affair is beneficial to one client the other is bound to suffer, relationship therapy is unlikely to work if one spouse is investing in a

relationship outside of the marriage, and because such behavior is illegal in some states, the counselor who promotes it may be liable for criminal conspiracy or alienation of affection civil suits (Margolin, 1982; Paulsen, Wadlington, & Goebel, 1974). Counselors should examine their position on the question and incorporate the ideas of both spouses to determine if therapy should be continued.

Sex Roles. Counselors bring their own interpretations both descriptive and conceptual to the counseling process including their own socialization experiences based on gender (Weiner & Boss, 1985). Even today, Patten et al. (1991) suggest that family counselors may be vulnerable to certain biases found in the APA's Task Force (1975) report, "Sex Biases and Sex-Role Stereotyping". Included in the report are statements that suggest that a) staying in the marriage would be better for the woman, b) less attention should be paid to a woman's career, c) the responsibility for child rearing should be placed on a woman, d) a double standard on extramarital affairs should be promoted for husbands and wives, and e) more importance should be placed on the husband's needs over those of the wife. These clearly reflect a gender bias. Based on the Task Force findings APA (1975) recommended that the options explored between the client and the counselor be free of sex-role stereotypes.

Weiner and Boss (1985) point to the absence of substantial knowledge about women's development and to the risk of relying on traditional gender role norms in working with women today. They suggest ethical guidelines for reducing bias in therapy including a) an evaluation of marriage by the husband

and wife as equal partners, b) a consideration of the discriminating experiences the female client may be enduring, c) an examination of the many roles which the female client is expected to fulfill, d) a consideration of both partners' sexual needs, e) returning power to both husband and wife if power techniques such as those used in strategic therapy are used, f) applauding assertiveness, g) promoting equal input from the husband and wife regarding counseling goals, fees, appointment times, and who is to be involved, h) being consistent in a policy regarding confidentiality, i) remaining current on gender research, and j) accepting a moral responsibility for reporting abuse.

While Wendorf and Wendorf (1985) agree about the needed changes in societal views of sex-role stereotyping, they contend that this focus on feminist family therapy is an imposition of personal values on the therapeutic process. They also contend that there may well be negative consequences to pushing these values onto their clients. The issue of the harmful effects of sex-role stereotyping and how this is addressed in family counseling is not without controversy. It is here that what constitutes personal values and professional ethics becomes debated.

Ethical Decision-Making Models

Ethical codes of a profession provide guidelines regarding moral conduct for a particular group (Huber & Baruth, 1987). They are intended to provide professional standards which can be used to guide members in decision-making when ethical conflicts arise. Corey et al. (1984) note that the guidelines

presented in a profession's code of ethics are usually general and represent standards of behavior that are minimal rather than ideal. In addition, from the preceding pages it is clear that professional ethical codes, while necessary, are often insufficient when family counselors are confronted with complex ethical dilemmas. Mabe & Rollin (1986) note the following limitations of professional ethical codes:

* Some issues cannot be handled by ethical codes alone.
* There are problems with enforcing codes; courts may decide that the codes are not applicable.
* There are conflicts within codes and between them.
* Codes may conflict with institutional policies and practices.
* Codes tend to spring from past events (p. 5).

Ethical codes often reflect what most professionals can agree on (Kitchner, 1984) rather than representing the ideal practice. Membership in various professional organizations and their divisions may also create additional ethical dilemmas due to differences in codes of ethics.

It is recommended that counselors and counselor educators go beyond the learning and teaching of ethical codes. Van Hoose (1986) suggests that counselors develop a clear process in understanding not just the ethical codes but ethical decision-making as well. Professional judgement and ethical reasoning are needed in resolving ethical dilemmas (Corey, et al., 1984) Two ethical decision-making models are briefly presented which are intended to facilitate

ethical decision-making in family counseling.

Kitchner's Model

Kitchner (1986) has developed a model of ethical decision-making which can aid family counselors in evaluating the consequences of their clinical decisions. Zygmond and Boorhem (1989) note that the use of ethical decision-making models is an uncommon practice in family counseling. They contend that family counselors tend to rely on their theoretical models of family counseling in ethical decision-making. Kitchner's model (1986) is based on the premise that ethical decisions are often dependent on the context. It is a tiered approach which moves to increasingly more abstract levels of ethical reasoning (Zygmond & Boorhem, 1989).

Her model begins with the intuitive level in which common sense can be used. She suggests this is often used with ethical dilemmas that are frequently encountered or predicted and prepared for in advance. She suggests, however, that all too frequently moral intuition is insufficient when counselors are presented with situations which may not have been considered beforehand, when an immediate decision is necessary, or when there are no clear professional guidelines on which to depend. She also suggests that intuition does not necessarily lead to good ethical decisions.

Kitchner (1986) recommends that counselors initially look to their ethical codes, then to ethical principles, and finally to ethical theory when confronted with ethical conflicts. In situations when ethical codes do not resolve

the conflict she recommends using ethical principles including autonomy, beneficence, nonmaleficience, fidelity, and justice. These are the cornerstones used in the critical evaluation of ethical decision-making in her model.

However, as noted in earlier discussion, these principles are often in conflict in the practice of family counseling. She identifies two ethical theories which can then be used when ethical principles do not resolve the dilemma. These theories involve the generalizability and balancing principles. According to the generalizability principle an ethical decision is ethical only when it can unambiguously be generalized to all similar cases. The balancing principle states that when making an ethical decision that the possible harm be balanced against the possible benefits to the client(s). This model is as applicable in family counseling as it is in individual counseling. It helps to guide ethical decision-making when conflicts arise in a number of different arenas and the ethical codes are insufficient.

Woody's Model

Woody (1990) proposes a model which can also be useful in resolving ethical dilemmas in family counseling. She agrees with Kitchner (1986) in that often many potential ethical dilemmas are resolved on an intuitive basis and suggests that this is a result of an internalization of a basic ethical stance towards clinical treatment. She, like Kitchner, acknowledges that intuitive reasoning is often insufficient in ethical decision-making.

Intuitive reasoning is based on absolutism, in Woody's model, which are

comprised of internalized ethical rules and principles. When these rules or principles are inadequate in guiding the ethical decisions the utilitarian theory of ethics can then be applied. This principle is based on producing the greatest good to the greatest number of people affected by the decision. She does not necessarily advise using the utilitarian ethical theory in most cases. However, she does suggest that when absolutism theory of ethics is insufficient use of the utilitarian theory can be defended.

Although professional codes of ethics appear to rely on an absolutism theory of ethics, Woody notes that, in fact, these rules are open to definition and meaning. Many of these rules, as has been noted, are often contradictory. Particularly in family counseling, the ethical codes are notably lacking in guidance. Additionally, these conflicts stem from the variability of the different theories and techniques of family counseling. Theoretical frameworks imply certain ethical behaviors and can be of benefit in making ethical decisions. Woody suggests that basing ethical decisions solely on the basis of theoretical orientation, however, contributes not only to the ethical debate in family counseling but also to the fact that most theoretical orientations do not consider other decision bases in their frameworks.

Woody acknowledges the emerging importance of the multicultural and legal contexts involved in ethical decisions. She identifies a sociolegal decision base which she believes needs to be taken into consideration in resolving ethical dilemmas. This base addresses the issues of examining one's own personal values

and the ongoing evaluation of social values This, she notes, is particularly true in family counseling where values related to minority cultures, sex-roles, and family values are currently changing. The sociolegal decision base also encompasses the current legal realities which complicate and contribute to thorny dilemmas faced by family counselors. She sees the consumer movement and the increasing regulation of the practice of mental health counseling (i.e., state licensure and certification) as contributing to the importance of considering the sociolegal dimension in the ethical decision-making process.

In Woody's model the organizational context, also changing, has an impact on ethical decisions. She notes that it is important to analyze the degree to which the setting and the role of the counselor affect ethical decisions. Lastly, Woody argues that the personal and professional identity of the professional impacts the decision-making process in resolving ethical conflicts. She believes this identity influences the choices counselors make in terms of theoretical orientation, as well as the factors which they consider to be relevant in a particular situation. The overall stability of the counselor is also considered an important dimension in resolving ethical conflicts.

Woody's model explores five decision bases which she believes are important dimensions that need to be explored when making ethical decisions. This model can be effective in aiding family counselors in their ability to identify the sources of potential conflict, thus facilitating decision-making abilities. Analyzing these different decision bases: theories of ethics, professional codes of

ethics, professional theoretical premises, the sociolegal context in which counseling takes place, and the counselor's personal and professional identity can help guide family counselors in resolving ethical issues.

Implications for Training

Traditionally, counseling programs have focused on individual and group counseling theories, techniques, and practice. As more training programs offer marriage and family coursework and specialization, more emphasis may need to be given to ethical issues unique to this area.

Marriage and family counseling involves a different conceptual framework than individual counseling. Counselors who have been trained primarily as individual counselors may have difficulty making ethical decisions which involve a focus on relationship systems. General professional codes of ethics may not prepare counselors adequately to anticipate ethical dilemmas. Counseling multiple clients may involve more complex issues. In addition, specialty ethical guidelines also do not address many of the ethical dilemmas faced by many marriage and family counselors.

The literature suggests that frequently the theoretical orientation of marriage and family counselors determines the manner in which ethical conflicts are resolved. As both Kitchner (1986) and Woody (1990) note there is the danger that counselors may, even unknowingly, impose their values on their clients.

The implications for counseling programs are that counseling graduates

may be unprepared to sufficiently resolve ethical conflicts that arise in marriage and family counseling. Many programs do not require a course in ethical issues in counseling relying rather on parts of other courses to address these issues. Additionally, many states do not require a specific course in ethical issues for licensure or certification.

Ethical issues in marriage and family counseling may also be covered as part of a class. When ethical issues courses are taught, those issues unique to marriage and family counseling may not necessarily be addressed. Furthermore, CACREP guidelines for specialization in marriage and family counseling do not require a specific course in ethical issues in marriage and family counseling. Therefore, it is quite possible that students of traditional counseling programs may have little exposure to ethical issues and conflicts in this area.

Counseling programs can respond to this potential deficiency by placing a greater focus on ethical issues encountered in marriage and family counseling. Teaching several models of ethical decision-making may also facilitate the development of the reasoning skills necessary for resolving complex issues in marriage and family counseling.

Recently ethical issues in the practice of counseling have received a considerable amount of attention. As traditional counseling programs become more involved in the training of marriage and family counselors serious consideration needs to be given to adequate preparation in resolving marriage and family ethical dilemmas. The research suggests that marriage and family

counselors trained through workshops tend to face significantly more ethical dilemmas than those trained through education or supervision (Green & Hansen, 1986). Clearly those involved in preparing marriage and family counselors must attend to the ethical issues and concerns which center on defining the client, informed consent, non-participating family members, confidentiality, diagnostic systems, power and control and differing client and counselor values.

References

American Association for Marriage and Family Therapy. (1988). AAMFT code of ethical principles for marriage and family therapists. Washington, D C: Author

American Psychiatric Association. (1987). Diagnostic and statistical manual (rev. 3rd ed.). Washington, DC: Author.

American Psychological Association. (1975). Report of the task force on sex bias and sex role stereotyping in psychotherapeutic practice. American Psychologist, 30, 1169-1175.

Aponte, H. (1985). The negotiation of values in therapy. Family processes, 24, 323-338.

Basel, K. (1989). Working with families: A practioner's perspective. Professional School of Psychology, 4, 261-263.

Boszormenyl-Nagy, I. (1985). Commentary: Transgenerational solidarity - Therapy's mandate and ethics. Family Process, 24, 454-456.

Boszormenyl-Nagy, I. (1986). Transgenerational solidarity: The expanding context of therapy and intervention. American Journal of Family Therapy, 14, 195-212.

Corey, G., Corey, M. S., & Callahan, P. (1984). Issues and ethics in the helping profession (2nd ed.). Monterey, CA: Brooks/Cole.

Denton, W. H. (1989). DSM-III-R and the family therapist: Ethical considerations. Journal of Marital and Family Therapy, 15, 367-377.

Doherty, W. J. (1985). Values and ethics in family therapy. Counseling and Values, 30, 3-8.

Engel, G. L. (1980). The clinical application of the biopsychosocial model. American Journal of Psychiatry, 137, 535-544.

Fenell, D. L., & Weinhold, B. K. (1989). Counseling families: An introduction to marriage and family therapy. Denver: Love Publishing Company.

Fieldsteel, N. D. (1982). Ethical issues in family therapy. In M. Rosenbaum (Ed.), Ethics and values in psychotherapy: A guidebook. New York: Free Press.

Fisher, L., Anderson, A., & Jones, J. (1981). Types of paradoxical interventions and indictors/counterindicators for use in clinical practice. Family Process, 20, 25-35.

Frances, A., Clarkin, J. F., & Perry, S. (1984). DSM-III and family therapy. American Journal of Psychiatry, 141, 406-408.

Green, S. L., & Hansen, J. C. (1986). Ethical dilemmas in family therapy. Journal of Marital and Family Therapy, 12, 225-230.

Green, S. L., & Hansen, J. C. (1989). Ethical dilemmas faced by family therapists. Journal of Marital and Family Therapy, 15, 149-158.

Gurman, A. (1985). On saving marriages. Family Therapy Networker, 9, 17-18.

Gurman, A., & Kniskern, D. (1981). Family therapy outcome research: Knowns and unknowns. In A. Gurman & D. Knisktern (Eds.), Handbook of family therapy

(pp 742-775). New York: Brunner/Mazel.

Haley, J. (1976). Problem-solving therapy: New strategies for effective family therapy. San Franscisco: Jossey-Bass.

Haley, J. (1987). Problem-solving therapy. San Francisco: Jossey-Bass.

Hare. R. (1981). The philosophical basis of psychiatric ethics. In S. Block & D. Chodoff (Eds.), Psychiatric ethics (pp 31-45). Oxford: Oxford University Press.

Hare-Mustin, R. (1980). Family therapy may be dangerous to your health. Professional Psychology, 11, 31-21.

Heatherington, L. (1990). Family therapy, control, and controllingness. Journal of Family Psychology, 4, 132-150.

Hines, P., & Hare-Mustin, R. (1978). Ethical concerns in family therapy. Professional Psychology, 9, 165-171.

Hoffman, L. (1981). Foundations of family therapy. New York: Basic Books.

Huber, C. H., & Baruth, L. G. (1987). Ethical, legal and professional issues in the practice of marriage and family therapy. Columbus, OH: Merrill.

Hundert, E. M. (1987). A model for ethical problem solving in medicine, with practical applications. American Journal of Psychiatry, 144, 839-846.

Jenson, P. S., Josephson, A. M., & Frey, J. (1989). Informed consent as a framework for treatment: Ethical and therapeutic considerations. American Journal of Psychotherapy, 43, 378-386.

Karpel, M. A. (1980). Family secrets: I. Conceptual and ethical issues in the

relational context II. Ethical and practical considerations in therapeutic management. Family Process, 19, 295-306.

Kitchner, K. S. (1984). Intuition, critical evaluation and ethical principles: The foundations for ethical decisions in counseling psychology. Counseling Psychologist, 12, 43-55.

Kitchner, K. S. (1986). Teaching applied ethics in counselor education: An integration of philosophical analysis. Journal of Counseling and Development, 64, 306-310.

Langsley, D. G., & Kaplan, D. M. (1968). The treatment of families in crisis. New York: Grune & Stratton.

Leigh, G. K., Loewen, I. R., & Lester, M. E. (1986). Caveat emptor: Values and ethics in family life education and enrichment. Family Relations, 35, 573-580.

Mabe, A. R., & Rollin, S. A. (1986). The role of a code of ethical standards in counseling. Journal of Counseling and Development, 64, 294-297.

Margolin, G. (1982). Ethical and legal considerations in marital and family therapy. American Psychologist, 37, 788-801.

Metcoff, J., & Whitaker, C. A. (1982). Family microevents: Communication patterns in problem solving. In F. Walsh (Ed.), Normal family processes (pp. 251-276). New York: Guilford.

Miller, T. R., Scott, R., & Searight, H. R. (1990). Ethics for marital therapy and subsequent training issues. Family Therapy, 17, 163-171.

Minuchin, S. (1974). Families and family therapy. Cambridge, MA: Harvard University Press.

Morrison, J., Layton, B., & Newman, J. (1982). Ethical conflict in decision making: A challenge for family therapists. In L. L'Abate (Ed.), Values, ethics, legalities, and the family therapist (pp 81-85). Baltimore: Aspen.

Napier, A., & Whitaker, C. (1978). The family crucible. New York: Harper & Row.

Nichols, M. (1984). Family therapy: Concepts and methods. New York: Gardner Press.

Okun, B. F., & Rappaport, L. J. (1980). Working with families: An introduction to family therapy. North Scituate, MA: Duxbury Press.

O'Shea, M., & Jessee, E. (1982). Ethical, value, and professional conflicts in systems theory. In L. L'Abate (Ed.), Values, ethics, legalities, and the family therapist pp 92-101). Rockville, MD: Aspen.

Papp. P. (1980). The Greek chorus and other techniques of family therapy. Family Process, 19, 45-57.

Patten, C., Barnett, T., & Houlihan, D. (1991). Ethics in marital and family therapy: A review of the literature. Professional Psychology: Research and Practice, 22, 171-179.

Paulsen, M. R., Wadlington, W., & Goebel, J. (1974). Cases and other materials on domestic relations. Mineola, N.Y.: Foundation Press.

Rokeach, M. (1973). The nature of human values. New York: Macmillan.

Shackle, E. M. (1985). Psychiatric diagnosis as an ethical problem. Journal of Medical Ethics, 1, 132-134.

Shoham-Salomon, V., Avner, R., & Neeman, R. (1989). You've changed if you do and changed if you don't: Mechanisms underlying paradoxical interventions. Journal of Consulting and Clinical Psychology, 57, 590-598.

Sider, R., & Clements, C. (1982). Family or individual therapy: The ethics of modality of choice. American Journal of Psychiatry, 139, 1455-1459.

Sluzki, C. E. (1978). Marital therapy from a systems perspective. In T. J. Paolino & B. S. McCrady (Eds.), Marriage and marital therapy: Psychoanalytic, behavioral, and systems theory perspectives pp 366-394). New York: Brunner/Mazel.

Smith, D. (1981). Unfinished business with informed consent procedures. American Psychologist, 36, 22-26.

Stricker, G. (1982). Ethical issues in psychotherapy research. In M. Rosenbaum (Ed.), Ethics and values in psychotherapy: A guidebook (pp 403-424.) New York: Free Press.

Stuart, R. B. (1980). Helping couples change. New York: Guilford.

Szaz, T. (1961). The myth of mental illness. New York: Dell.

Teismannn, M. (1980). Convening strategies in family therapy. Family Process, 19, 393-400.

Treacher, A. (1988). The Milan method - A preliminary critique. Journal of Family Therapy, 10, 1-8.

Van Hoose, W. H., Kottler, J. A. (1985). Ethical and legal issues in counseling and psychotherapy. San Francisco: Jossey-Bass.

Van Hoose, W. (1986). Ethical principles in counseling. Journal of Counseling and Development, 65, 168-169.

Watzlawick, P., Weakland, J., & Fisch, R. (1974). Change: Principles of problem formation and problem resolution. New York: Norton.

Watkins, S. A. (1989). Confidentiality: An ethical and legal conundrum for family therapists. American Journal of Family Therapy, 17, 291-362.

Weiner, J. P., & Boss, P. (1985). Exploring gender bias against women: Ethics for marriage and family therapy. Counseling and Values, 30, 9-23.

Wendorf, R. J., & Wendorf, D. J. (1985). Rejoinder: Looking high and low. Family Process, 24, 457-460.

Wilcoxon, S. A. (1986). Engaging non-attending family members in marital and family counseling: Ethical issues. Journal of Counseling and Development, 64, 323-324.

Wilcoxon, A., & Fenell, D. (1983). Engaging the non-attending spouse in marital therapy through the use of therapist-initiated written communication. Journal of Marital and Family Therapy, 9, 199-203.

Wilcoxon, S. A., & Gladding, S. T. (1985). Engagement and termination in marital and familial therapy: Special ethical considerations. American Journal of Family Therapy, 13, 65-71.

Whitaker, C. A., & Bumberry, W. M. (1988). Dancing with the family. New

York: Brunner/Mazel.

Woody, J. D. (1990). Resolving ethical concerns in clinical practice: Toward a pragmatic model. Journal of Marital and Family Therapy, 16, 133-150.

Yoell, W., Stewart, D., Wolpe, J., Goldstein, A., & Speirer, G. (1971). Marriage, morals and therapeutic goals: A discussion. Journal of Behavior Therapy and Experimental Psychiatry, 2, 127-132.

Zygmond, M. J., & Boorhem, H. (1989). Ethical decision making in family therapy. Family Process, 28, 269-280.